DBQ Guide – General

This guide provides a step-by-step guide for general issues common to all DBQs (Disability Benefits Questionnaires). For more information, please contact us at vesphysicianshelp@vesservices.com or through the Physician Help support link in your portal.

DBQs are tailored to VA's Schedule for Rating Disabilities, designed to collect medical evidence relevant to claims for benefits. One goal of DBQs is to improve transparency and standardization of the disability exam and claims evaluation process.

Veterans should be reminded that rating decisions are made at VBA regional offices (toll-free number 1-800-827-1000), not by examining clinicians.

1. Veteran's name and information

Specific Veteran information is at the top of the DBQ form, along with any instructions or comments from the VA that pertain to the case.

2. Diagnosis

All DBQs begin with the diagnosis, which is the "headline" for the report. The clinician may need to complete the diagnosis section after the evaluation is performed.

All DBQs start with the following question:

Does the Veteran now have or has he/she ever been diagnosed with "xyz" condition? (This is the condition the Veteran is claiming or for which an exam has been requested.)

If the Veteran has the claimed condition, answer "Yes" and continue completing the form.

If the Veteran does not have the claimed condition, select "No" and provide a brief explanation in the remarks section, including any available substantiating normal or negative diagnostic test results or any other information documenting the absence of the condition.

3. Date of Diagnosis

The date of diagnosis can be a precise date or an approximate date, such as "1990's" or "not known."

When applicable, VBA will use this information to assign date of benefit entitlement. If the condition is diagnosed during the Veteran's appointment, enter the date of the diagnosing evaluation.

4. ICD Codes

ICD codes appear on the DBQs in response to a request from Congress to improve data tracking. They have no bearing on VBA's evaluation of the Veteran's claim.

The clinician should provide a general ICD code for the claimed condition; there is no need to drill down to decimal points.

5. Medical record review

Some DBQs may have a section for medical record review. If the DBQ being completed does not have this section, it is still important to comment on the medical evidence that was reviewed. This should be documented in the Remarks section.

6. Medical History

Describe the history (including onset and course) of the Veteran's claimed condition (brief summary): _____

Provide the general history and current status of the claimed condition in a few concise sentences. This is not a Ratings Schedule criterion, but is used to provide the VBA evaluator with background information on the Veteran's condition. Please be as detailed as possible.

Medication (if requested in the DBQ):

Some DBQs request information about medications. Use of continuous medications is a rating criterion for a number of conditions. List only those medications prescribed to treat the claimed conditions.

Providing the dose and frequency if available gives the VA a more complete picture of the condition. Clinicians should not copy and paste entire medication list.

Some DBQs request information about current **status of disease**. "Active" indicates the Veteran is currently undergoing treatment. "Remission" indicates the Veteran has undergone treatment and is in "watchful waiting" or "active surveillance" status.

Some DBQs request information about **surgical treatment**. Providing the name of the treatment facility and date allows VA to more easily find supporting records and evidence, if needed.

A general description of the treatment facility, such as “Los Angeles VAMC” and an approximate date, such as “approximately January 2009,” is acceptable if the precise date is not available.

7. Findings, signs or symptoms
Some DBQs have this section, which contains check boxes for a list of historical symptoms and physical findings. The purpose for a mixed list of subjective symptoms and objective findings is to document Ratings Schedule criteria for VBA use in a single location. VBA may use these results to fill in their electronic Evaluation Builder. Tailoring exam reports to VBA rating needs helps Veterans by expediting claims evaluation.

8. Specific conditions
Some DBQs contain sections for specific conditions, such as Asthma, with check boxes for various manifestations or treatments for those conditions. The purpose of this is to document Ratings Schedule criteria for those specific conditions.

9. Physical Examination
Some DBQs have specific and detailed sections for physical exams, especially when certain physical findings are Rating Schedule criteria.

10. Tumors and neoplasms
Many DBQs contain a section on tumors and neoplasms. This section is for documentation of treatment and residual complications if the Veteran has a tumor or neoplasm.

11. Scars and other physical findings/conditions
All DBQs ask whether or not the Veteran has **“any scars (surgical or otherwise) related to any conditions or to the treatment of any conditions listed in the Diagnosis section.”**
Often there is a scar associated with a condition. By answering this question, the clinician lets the VA know the scar has been examined and that if the scar meets compensable criteria, a Scars DBQ will also be completed.
All DBQs ask if there are **“any other pertinent physical findings, complications, conditions, signs and/or symptoms.”**
This section provides an opportunity for the clinician to add any additional information or physical findings that he or she feels is necessary to make a medically and legally valid report.

12. Diagnostic Testing

The clinician may comment on whether or not the testing reflects the Veteran's current condition in the remarks section. However, if the test results do not reflect the Veteran's current condition, new testing may be required.

Some test results are Rating Schedule criteria, such as PFTs and METs; other test results are not Rating Schedule criteria but are needed to support the diagnosis.

Clinicians should not copy and paste entire results for imaging studies, but provide only the impression and brief summary. VBA has access to VHA electronic medical records and can review the full report when appropriate.

- Arthritis diagnoses MUST be supported by x-ray evidence or the diagnosis will not be accepted by the VA ratings board.
- Please do not request MRIs or EMGs; VA has advised that, with very few exceptions, these tests should not be required to render a diagnosis in the appropriate clinical setting.

13. Functional impact

Although not directly tied to Rating Schedule criteria, this important section provides the VA with a more complete picture of the Veteran's function, since VBA benefits are intended to compensate for average loss of earning potential due to service-connected conditions.

There is a section addressing Functional impairment in the Code of Federal Regulations. That section indicates that the medical examiner has the responsibility of furnishing, in addition to the etiological, anatomical, pathological, laboratory and prognostic data required for ordinary medical classification, full description of the effects of disability upon the person's ordinary activity.

The clinician should answer this question based on the Veteran's ability to perform typical occupational duties, such as bending, standing, sitting, walking or lifting, regardless of whether or not the Veteran is currently working. The answer should address only the functional limitations caused by the condition at issue, regardless of any limitations caused by any other medical conditions. Providing one or more examples in the Veteran's own words will help the VA more fully understand the Veteran's condition.

This section is not intended to represent an evaluation for Individual Unemployability.

14. Remarks, if any

This free text box provides clinicians with an opportunity to enter any additional information. This is where the clinician can provide further explanation for items checked in the body of the DBQ, if appropriate.
If the DBQ does not contain a section for medical records or C-file review, the clinician should document that here.
This is also where the clinician would document absence of a diagnosis, including pertinent normal exam findings or normal test results to substantiate this conclusion.